LIFE CODE COMPLIANCE COMMITTEE

Notice of Determination

by the Life Code Compliance Committee (Life CCC) on alleged non-compliance with the Life Insurance Code of Practice by a subscriber

Reference:	CX6026	**Date:**	25 June 2021
Code sections:	8.5, 8.7, 8.8, 8.15, 8.17, 8.20, 8.24, 8.25 [1]		
Investigation:	A consumer-reported alleged Code breach		

The alleged Code breach:

The Consumer is a member of a superannuation fund. As part of that membership, the Consumer obtained life insurance along with a Total and Permanent Disability (TPD) benefit. The life insurance policy was issued by a Life Insurance Company that is a subscriber (the Subscriber) to the Life Insurance Code of Practice (the Code), and the policy was a group policy which was owned by the superannuation fund trustee (the Trustee).

The Consumer made a TPD claim on 24 September 2018. Due to delays in the assessment of the TPD claim, the Consumer's legal representatives (CLR) lodged a Code breach allegation with the Life CCC and alleged that the Subscriber was in breach of sections 8.5, 8.7, 8.8, 8.17, 8.20, 8.24 and 8.25 of the Code.

The Subscriber disagreed with the Code breach allegations made by the Consumer but acknowledged a breach of section 8.15 of the Code as it did not provide the claims decision to the Trustee within 10 business days of receiving all the information that it required.

The timeline below provides an overview of the key events in the Consumer's TPD claim.

Date	Event
24 September 2018	Consumer lodged a TPD claim with the Trustee.
11 October 2018	The Trustee notified the Subscriber of the TPD claim, with a claimed date of disability of 29 November 2006.
19 October 2018	The Subscriber requested information from the Trustee in relation to the Consumer's return to work.
October 2018 – April 2019	The Subscriber assessed the Consumer's TPD claim and requested further information, including information relating to the Consumer's return to work attempt in 2016.
10 April 2019	The Subscriber informed the Trustee about the existence of Unexpected Circumstances in the claim (definition a).[2]

[1] The Code sections are provided in full in the last section of the Determination.
[2] Chapter 15. Definitions – Unexpected Circumstances a): Unexpected Circumstances means **your** claim has been notified to **us** more than 12 months after the later of the date of disability or the end of **your** waiting period, and there are reasonable delays obtaining evidence necessary for the assessment of **your** claim from the intervening period.

26 April 2019	The Subscriber received all the information that it needed to make a decision on the claim.
3 May 2019	The Subscriber's claims assessor made a recommendation to admit the claim.
24 May 2019	The decision to accept the claim was sent to the Trustee.

Findings in accordance with Charter clause 7.4(b)(iii)[3]:

The Life CCC determined that:

- section 8.8 of the Code did not apply in this matter and the allegation was unfounded,
- the Subscriber was not in breach of sections 8.5, 8.7, 8.17, 8.20, 8.24 and 8.25 of the Code and that the allegations were unfounded, and
- the Subscriber was in breach of section 8.15 of the Code and the allegation was proven in whole.

The Life CCC findings and conclusion:

Section 8.5

Section 8.5 requires a subscriber to only ask for and rely on information and assessments that are relevant to the claim, and to explain the reasons for requesting information.

The CLR alleged that the Subscriber was in breach of section 8.5 as the Subscriber requested information about the Consumer's return to work in 2016. The CLR claimed that the information was not required for the Subscriber to finalise its assessment of the Consumer's claim.

The Consumer's policy was initially a group policy issued by the Subscriber that was in force until 30 June 2011. From 1 July 2011, another insurer issued the group insurance policy held by the Trustee for the benefits of its members (including the Consumer).

While the Consumer's claimed disability date was in 2006, the Subscriber noted that it required information about the Consumer's return to work attempt in March 2016 to confirm if the Consumer was eligible for cover under the Subscriber's group policy. If the Consumer was deemed to have returned to work in 2016, the Consumer would then have to be assessed under the policy that came into force on 1 July 2011.

The Subscriber confirmed that it communicated this to the Trustee when it requested the Consumer's return to work information, and also informed the Trustee that it should notify the Subscriber if the Trustee had any concerns in relation to the information requested.

Based on the information available, the Subscriber's request for the Consumer's return to work information in 2016 was relevant to the claim and was a reasonable request for information. In addition, the Subscriber correctly notified the Trustee regarding the reasons for requesting the information, and also notified the Trustee of its right to disagree with the information request.

After reviewing all the information available, the Life CCC determined that the Subscriber was not in breach of section 8.5 of the Code and that the allegation was unfounded.

[3] The Life CCC is bound by its Charter to use the terminology 'the reported allegation was proven in whole or in part or was unfounded.' This in essence requires the Life CCC to state if it determined there was a breach or not. The Life CCC will explain its determination in plain language in the body of the Determination.

Section 8.7

Section 8.7 of the Code creates an obligation for a subscriber to request the information that it needs as early as possible and to avoid multiple information requests where possible.

The Life CCC reviewed the Subscriber's compliance with section 8.7 and noted that the Subscriber initially requested the Consumer's return to work information on 19 October 2018, 6 business days after being notified of the Consumer's TPD claim.

Due to various factors including the Consumer's ex-employer requesting a $300 fee to provide the information, the information requested by the Subscriber was only received on 26 April 2019. In addition, the Life CCC noted that the Subscriber did not make multiple information requests in relation to this information.

As the Subscriber requested the information 6 business days after being notified of the claim, the Life CCC determined that the Subscriber was not in breach of section 8.7 of the Code and that the allegation was unfounded.

Section 8.8

If a subscriber requests a report from an Independent Service Provider (ISP), section 8.8 of the Code requires the subscriber to ask for the report to be provided to them no later than 4 weeks after the date of the request.

The Subscriber has confirmed that while it requested information from a number of sources in relation to the Consumer's return to work, it did not request a report from any ISPs in relation to this claim. We note that the information requested from the Consumer's ex-employer does not qualify as a report from an ISP.

As a result, the Life CCC determined that section 8.8 of the Code did not apply to this matter and that the allegation was unfounded.

Section 8.15

Section 8.15 of the Code requires a subscriber to communicate its decision on the claim within 10 business days of receiving all the information that it reasonably needs and completing all reasonable enquiries.

The Subscriber received all the information that it needed to assess the claim on 26 April 2019. This meant that the Subscriber had to provide the Trustee with its decision on the claim by 10 May 2019. However, the Subscriber communicated its decision to the Trustee on 24 May 2019, 20 business days after receiving all the information that it required and 10 business days after the section 8.15 timeframe expired.

The Subscriber noted that the decision to accept the claim was made on 3 May 2019 and payment was sent to the Trustee for processing on the same day. Due to an internal oversight, this was not communicated to the Trustee. The Subscriber realised this error and communicated the claim decision to the Trustee on 24 May 2019 after it received an update request from the Trustee on 23 May 2019.

The Subscriber has acknowledged that this delay amounted to a breach of section 8.15 of the Code. The Subscriber has advised all claims assessors involved in the assessment of the Trustee's claims of this incident and reminded them of the process to communicate decisions within 10 business days of receiving all the information required.

The Subscriber has also acknowledged that its compliance arrangements in relation to section 8.15 were not adequate. This was primarily in relation to there being no monitoring control in

place to assist case managers in monitoring Code timeframes, as well the risk of human error due to manual input of data into its claims system. As at August 2020, the Subscriber has commenced the use of an automated claims system and implemented a new reporting tool which acts as a monitoring control.

After reviewing all the information available, the Life CCC determined that the Subscriber was in breach of section 8.15 of the Code, that the allegation was proven in whole, and that the breach of section 8.15 amounted to serious and systemic non-compliance with the Code.

Section 8.17

Section 8.17 of the Code requires a subscriber to provide its decision on a lump sum claim within 6 months, unless Unexpected Circumstances (UC) applies. If UC applies, the subscriber has 12 months to provide its decision on the claim.

The CLR alleged that the Subscriber was in breach of section 8.17 of the Code as it failed to provide its decision on the claim within 6 months. The Consumer lodged their claim with the Trustee on 24 September 2018, and the Subscriber was notified of the claim by the Trustee on 11 October 2018.

As a result, the Subscriber's 6 month timeframe in section 8.17 started on 11 October 2018, when it was notified of the claim. This meant that the Subscriber had to provide its decision on the claim by 11 April 2019 unless UC applied.

The Subscriber noted that definition (a) of UC[4] in Chapter 15 applied to the claim as the Consumer's date of disability was in 2006 and there were reasonable delays in obtaining the evidence necessary for the assessment of the claim. The Subscriber notified the Trustee of the existence of UC on 10 April 2019 via a letter. As the Trustee is not a subscriber to the Code, the Trustee's conduct in referring the UC letter to the Consumer is not covered under the Code.

The Subscriber subsequently provided its decision on the claim to the Trustee on 24 May 2019, approximately 7 months after it was notified of the claim and within the 12 month UC timeframe. After reviewing all the information available, the Life CCC determined that the Subscriber was not in breach of section 8.17 of the Code and that the allegation was unfounded.

Section 8.20

Section 8.20 of the Code requires subscribers to have claims assessors who are appropriately skilled and trained to make objective decisions, and to only allow assessors who have demonstrated technical competency to make decisions. In addition, remuneration and entitlements will not be based on declined or deferred claim decisions.

The CLR alleged that the Subscriber's claims assessor in this instance was not appropriately skilled and trained to make objective decisions.

The Subscriber noted that it has an onboarding compliance induction and ongoing training program in place for claims staff. It also approved claims assessment delegations in place which are aligned to demonstrated technical competency of claims staff. The Subscriber has also confirmed that its remuneration and bonus structure is not based on declined claims or deferral of claim decisions.

[4] Chapter 15, Definitions – Unexpected Circumstances a): Unexpected Circumstances means **your** claim has been notified to **us** more than 12 months after the later of the date of disability or the end of **your** waiting period, and there are reasonable delays obtaining evidence necessary for the assessment of **your** claim from the intervening period.

Based on the information available, there was no evidence to indicate that the Subscriber's claims assessor was not appropriately skilled and trained, and the Life CCC determined that the Subscriber was not in breach of section 8.20 of the Code and that the allegation was unfounded.

Section 8.24

Section 8.24 requires subscribers to treat consumers with compassion, respect and empathy. The CLR alleged that the Subscriber had not shown the Consumer any compassion for their difficult physical and financial circumstances.

The Subscriber noted that it treated the Consumer with compassion and respect, including offering an alternative solution to the provision of the Consumer's return to work information.

The Subscriber's arrangement with the Trustee meant that the Subscriber was not in direct contact with the Consumer, with the Subscriber and the Consumer both dealing with the Trustee. The Trustee would then relay information between the Subscriber and the Consumer. While the Consumer noted that they informed the Trustee of their financial hardship, the Subscriber has confirmed that this information was not provided to it by the Trustee.

Given that the Subscriber was unaware of the Consumer's hardship and that there was no evidence to indicate that the Subscriber failed to treat the Consumer with compassion, respect and empathy, the Life CCC determined that the Subscriber was not in breach of section 8.24 of the Code and that the allegation was unfounded.

Section 8.25

When a consumer tells a subscriber that they are having difficulty providing the requested claim information, section 8.25 of the Code requires a subscriber to work with the consumer to find a solution. This will include efforts to collect the information on behalf of the consumer.

The CLR alleged that the Subscriber was in breach of section 8.25 of the Code as the Subscriber made no attempt to work with the CLR to find a solution as to how to obtain the requested information in relation to the failed return to work.

The Subscriber noted that it did not specifically communicate with the CLR or the Consumer in relation to this claim and was not informed that the CLR was having difficulty in providing the requested information. The Subscriber noted that it was advised by the Trustee on 7 December 2018 that the CLR would assist with obtaining employment information in relation to the Consumer's return to work.

On 10 January 2019, the Trustee provided the Subscriber with a copy of a letter dated 18 December 2018 from the CLR noting that there was no valid reasons for the Subscriber to request this information and accordingly the information was not provided to the Subscriber. The Subscriber subsequently requested the Trustee to obtain alternative employment information which included tax records, which the Subscriber received on 26 April 2019.

Given the above, there was no evidence to indicate that the Consumer told the Subscriber that they were having difficulty providing the information and that the Subscriber then subsequently failed to work with the Consumer to find a solution. After reviewing all the information available, the Life CCC determined that the Subscriber was not in breach of section 8.25 of the Code and that the allegation was unfounded.

Key learnings

The Consumer's policy in this instance required the Trustee to relay information between the Subscriber and the Consumer. This meant that information was not always communicated to the Consumer or the Subscriber, resulting in some misunderstandings on the claim.

The Life CCC notes that the Trustee is not a subscriber to the Code and the Trustee's conduct is not covered under the obligations in the Code. However, subscribers should take the initiative to ensure that any communications that it provides to the Trustee are accurately conveyed to consumers in a timely manner. Subscribers should also remind Trustees of the need to provide relevant information and communications from consumers to subscribers in a timely manner.

Relevant Code Sections

Section 8.5:

We will only ask for and rely on information and assessments that are relevant to **your** claim and policy, and **we** will explain why **we** are requesting these. This can include, for example, financial, occupational and medical information. If **you** disagree with the relevance of any information, **we** will review the request, and if **you** are not satisfied with **our** review **we** will tell **you** how **you** can make a **Complaint**.

Section 8.7:

We will request the information **we** need as early as possible and will avoid multiple information requests where possible.

Section 8.8:

If **we** request a report from an **Independent Service Provider**, **we** will ask for the report to be provided to **us** no later than four weeks after the date of request or the date of **your** appointment (if **you** are required to attend one). If the **Independent Service Provider** fails to meet this timeframe, **we** will inform **you** of this, and keep **you** informed of **our** progress in obtaining the report.

Section 8.15:

Once **we** have all the information **we** reasonably need and have completed all reasonable enquiries to assess **your** claim, including **your** response to the evidence **we** are basing **our** decision on if **we** have presented this to **you**, **we** will let **you** know **our** decision on **your** claim within ten **business days**.

Section 8.17:

For all claims other than income-related claims, **we** will let **you** know **our** decision no later than six months after **we** are notified of **your** claim or six months after the end of any waiting period, unless **Unexpected Circumstances** apply. Depending on **your** policy, **our** decision may be a requirement that **you** undertake a period of rehabilitation or retraining, or it may be a final decision on **your** benefits. Where **Unexpected Circumstances** apply, **our** decision will be made no later than 12 months after **we** are notified of **your** claim. **We** will let **you** know the reasons for the delay, and if **you** disagree **we** will review this. If **we** cannot make a decision within 12 months, **we** will give you details of **our Complaints** process.

Section 8.20:

Our claims assessors will be appropriately skilled and trained to make objective decisions. They will not make claims decisions on **our** behalf until they have demonstrated technical competency and an understanding of all relevant law, the **Code** and relevant **FSC** Standards and Guidance. Remuneration and entitlements to bonuses will not be based on declined claims or deferrals of decisions

Section 8.24:

We acknowledge that claims time is difficult for **our** customers, and that empathy is required in **our** claims management. **We** will treat **you** with compassion and respect

Section 8.25:

If **you** tell **us** that **you** are having difficulty providing requested claim information **we** will work with **you** to find a solution. This will include endeavours to collect the information on **your** behalf.

The Life CCC is the independent body responsible for the administration and enforcement of the Life Insurance Code of Practice (the Code). It acts in accordance with the Life CCC Charter, which sets out the powers, duties, functions and responsibilities of the Committee, subject to any provisions in the Code. This Determination is issued in accordance with clause 7.4 of the Life CCC's Charter in order to facilitate agreement between the Life CCC and the Subscriber on corrective measures and the relevant timeframes for their implementation.